DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **02-013**

2. STATE: IDAHO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **November 1, 2002**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR 447.253**

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ (1,987,244.18)
b. FFY 2004 $ (2,164,529.72)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19 A – Sections 449 to 456**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19 A – Sections 449 to 456**

10. SUBJECT OF AMENDMENT: **Changes the base percentage for hospitals reimbursed by Idaho Medicaid. Legal Notice was published on October 24, 2002.**

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Karl B. Kurtz

13. TYPED NAME: **KARL B. KURTZ**

14. TITLE: **Director**

15. DATE SUBMITTED:

16. RETURN TO:
Joseph R. Brunson, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: FEB 20 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL: Brownfn Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

449. MAXIMUM PAYMENT TO HOSPITALS. Pursuant to the provisions of Title XIX of the Social Security Act, in reimbursing hospitals, the Department will pay in behalf of MA recipients the lesser of Customary Charges or the Reasonable Cost of inpatient services in accordance with procedures detailed in Sections 450 through 499. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment which would be determined as a Reasonable Cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement.

- Indian Health Hospitals. Payment for Indian Health Services (IHS)/tribal 638 inpatient hospital services is made at the most current inpatient hospital per diem rate published by IHS in the Federal Register.

450. EXEMPTION OF NEW HOSPITALS. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of Reasonable Cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs.

451. DEFINITIONS. In determining hospital reimbursement on the basis either of Customary Charges or of the Reasonable Cost of inpatient services under Medicaid guidelines, whichever is less, the following will apply:

- Allowable Costs. The Current Year's Title XIX apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual Parts I and II (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation.

- Apportioned Costs. Apportioned Costs consist of the share of a hospital's total allowable costs attributed to Medicaid program recipients and other patients so that the share borne by the program is based upon actual services received by program recipients, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in Provider Reimbursement Manual, PRM—15, and in compliance with Medicaid reimbursement rules.

- Capital Costs. For the purposes of hospital reimbursement, Capital Costs are those allowable costs considered in the final settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes.

- Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the Current Year will be divided by the index of the Principal Year to assess the percent change between the years.
- Charity Care. Charity Care is care provided to individuals who have no source of payment third-party or personal resources.
- Children's Hospital. A Children's Hospital is a Medicare certified hospital as set forth in 42 CFR Section 412.23 (d)
- Cost Report. A Cost Report is the complete Medicare cost reporting form Centers For Medicare and Medicaid Services (CMS) 2552, or its successor, as completed in full and accepted by the Intermediary for Medicare cost settlement and audit.
- Current Year. Any hospital cost reporting period for which Reasonable Cost is being determined will be termed the Current Year.
- Customary Charges. Customary Charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services and billed to the Title XIX program. No more than ninety-six and one-half percent (96.5%) of covered charges will be reimbursed for the separate Operating Costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 453.
- Disproportionate Share Hospital (DSH) Allotment Amount. The Disproportionate Share Hospital (DSH) Allotment Amount is determined by CMS which is eligible for federal matching funds in the federal fiscal period for disproportionate share payments.
- Disproportionate Share Threshold. The Disproportionate Share Threshold shall be: a. the arithmetic mean plus one (1) standard deviation of the Medicaid Inpatient Utilization Rates of all Idaho hospitals; or, b. a Low Income Utilization Rate exceeding twenty-five percent (25%).

- DSH Survey. The DSH Survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH pursuant to Subsection 454.02.
- Excluded Units. Excluded Units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system.
- Hospital Inflation Index. The State will use the ACCRA Cost of Living Index published by the American Chamber of Commerce Researchers Association.
- Medicaid Inpatient Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH Survey. In this paragraph, the term "inpatient days" includes newborn days, days in specialized wards, and days provided to an inappropriate level of care. Days provided at an inappropriate level of care includes Medicaid swing-bed and administratively necessary days, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH Threshold computations.
- Low Income Utilization Rate. The Low Income Utilization Rate is the sum of the following fractions, expressed as a percentage: a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third party payers, or cash for patient services received directly from state and local governments county assistance programs.
- Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted.
- Obstetricians - For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

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Supersedes No. 95-016

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- Operating Costs. For the purposes of hospital reimbursement, Operating Costs are the allowable costs included in the cost centers established in the finalized Medicare Cost Report to accumulate costs applicable to providing routine, and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process.
- Other Allowable Costs. Other Allowable Costs are those Reasonable Costs recognized under the Medicaid Reasonable Cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as Operating Costs, but recognized by Medicare principles as Allowable Costs will be included in the total Reasonable Costs. Other Allowable Costs include, but are not necessarily limited to, physician's component which was combined-billed, Capital Costs, ambulance costs, excess costs carry-forwards and medical education costs.
- Principal Year. The Principal Year is the period from which the Title XIX inpatient operating cost limit is derived: a. For services rendered from July 1, 1987 through July 5, 1995, the Principal Year shall be the provider's fiscal year ending in calendar year 1984 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement: b. For inpatient services rendered after July 5, 1995, through June 30, 1998, the Principal Year shall be the provider's fiscal year ending in calendar year 1992 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement; c. For inpatient services rendered after June 30, 1998, the Principal Year shall be the provider's fiscal year ending in calendar year 1995 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement.
- Public Hospital. For purposes of Subsection 453, a Public Hospital is a hospital operated by a Federal, State, county, city, or other local government agency or instrumentality.

- Reasonable Costs. Except as otherwise provided in section 453. Reasonable Costs includes all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service, which do not exceed the Title XIX cost limit.
- Reimbursement Floor Percentage. The percentage of allowable Medicaid costs guaranteed of hospitals with licensed and Medicare certified inpatient bed for State Fiscal year ending June 30, 2002 and thereafter. Eighty-one an one half percent (81.5%).
- Reimbursement Ceiling Percentage. The percentage of allowable Medicaid costs to hospitals with licensed and Medicare certified inpatient beds will not exceed ninety-six an one half percent (96.5%) November 1, 2002 and thereafter.
- TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248.
- Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the State Allotment Amount, only inpatient costs of uninsured patients will be considered. An inpatient with insurance but no benefit covered for the particular medically necessary service, procedure or treatment provided is an uninsured patient.
- Upper Payment Limit. The Upper Payment Limit for hospital services shall be as defined in the Chapter 42 of the Code of Federal Regulations.

452. TITLE XIX INPATIENT OPERATING COST LIMITS: a. Title XIX Cost Limits for Dates of Service Prior to a Current Year. The reimbursable Reasonable Costs for services rendered prior to the beginning of the Principal Year, but included as prior period claims in a subsequent period's Cost Report will be subject to the same operating cost limits as the claims under settlement; b. Application of the Title XIX Cost Limit. In the determination of a hospital's Reasonable Costs for inpatient services rendered after the effective date of a Principal Year, a Hospital Inflation Index, computed for each hospital's fiscal year end, will be applied to the Operating Costs, excluding capital costs and other allowable costs as defined by Subsection 451 for the Principal Year and adjusted on a per diem basis for each subsequent year under the Hospital Inflation Index: (i) Each inpatient routine service cost center, as reported in the finalized Principal Year end Medicare Cost Report, will be segregated in the Title XIX cost limit calculation and assigned a share of total Title XIX inpatient ancillary costs. The prorated ancillary costs shall be determined by the ratio of each Title XIX routine cost center's reported costs to total Title XIX inpatient routine service costs in the Principal Year; (ii) Each routine cost center's total Title XIX routine service costs plus the assigned share of Title XIX inpatient ancillary costs of the Principal Year will be divided by the related Title XIX patient days to identify the total costs per diem in the Principal Year; The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in 452 to identify each inpatient routine service cost center per diem cost limit in the Principal Year; If a provider did not have any Title XIX inpatient utilization or render any Title XIX inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the Principal Year, the Principal Year for only those routine cost centers without utilization in the provider's Principal Year will be appropriately calculated using the information available in the next subsequent year in which Title XIX utilization occurred; c. Each routine cost center's cost per diem for the Principal Year will be multiplied by the Hospital Inflation Cost Index; d. The sum of the per diem cost limits for the Title XIX inpatient routine service cost centers of a hospital during the Principal Year, as adjusted by the Hospital Inflation Index, will be the Title XIX cost limit for Operating Costs in the Current Year. At the date of final settlement, reimbursement of the Title XIX Current Year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem Operating Costs as adjusted for each subsequent fiscal year after the Principal Year through the Current Year by the Hospital Inflation Cost Index. Providers will be notified of the Hospital inflation index upon written request.

453. ADJUSTMENTS TO THE TITLE XIX COST LIMIT. A hospital's request for review by the Bureau of Medicaid Policy and Reimbursement, or its successor, concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Sections 450 through 499, shall be granted under the following circumstances (see Appendix 1.):

- Adjustments Because of Extraordinary Circumstances. Where a provider's costs exceed the Title XIX limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects.
- Reimbursement to Public Hospitals. A Public Hospital that provides services free or at a nominal charge, which is less than or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to or greater than its costs.
- Adjustment to Cost Limits. A hospital shall be entitled to a reasonable increase in its Title XIX Cost Limits if the hospital shows that its per diem costs of providing services have increased due to increases in case-mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the Principal Year. Any hospital making such showing shall be entitled to an increase in its prevailing Title XIX Cost Limits commensurate with the increase in per diem costs; a. The Title XIX Operating Cost Limit may be adjusted by multiplying the ratio of the Current Year's Case-Mix Index divided by the Principal Year's Case-Mix Index. The contested case procedure set forth in IDAPA 16.05.03.330.02 shall be available to larger hospitals seeking such adjustments to their Title XIX Cost Limits.
- Hospitals will be guaranteed at least eighty percent (80%) of their total allowable Medicaid Operating and Capital and medical education costs upon final settlement, excluding DSH payments; a. With the exception of Subsection b, at the time of final settlement, the allowable Medicaid costs related to each hospital's fiscal year end will be according to the Reimbursement Floor Percentage defined for each state fiscal year end; b. In the event that CMS informs the Department that total hospital payments under the Inpatient Operating Cost Limits exceed the inpatient Upper Payment Limit, the Department may reduce the guaranteed percentage defined as the Reimbursement Floor Percentage to hospitals.

Adjustment to the Proration of Ancillary Costs in the Principal Year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total allowable Title XIX Operating, Capital and medical eduction costs, per diem calculated for the inpatient routine service cost centers in the Principal Year, the provider may submit a detailed analysis of ancillary services provided to each Title XIX recipient (for each type of patient day during each recipient's stay during the Principal Year). The provider will be granted this adjustment only once upon appeal prior to notice of program reimbursement for the provider's fiscal year ending.

454. Adjustment for Disproportionate Share Hospitals (DSH). All hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as a Deemed DSH to receive a DSH payment.

01. DSH Survey Requirements. On or before January 31, of each calendar year, the Department will send each hospital a DSH survey. Each hospital shall return the DSH Survey on or before May 31 of the same calendar year. A hospital shall not be entitled to a DSH payment if the hospital fails to return the DSH survey by the May 31 deadline without good cause as determined by the Department. From the DSH Survey and Department data, payments distributing the state's annual DSH allotment amount will be made by September 30 of the same calendar year.

02. Mandatory Eligibility for DSH Status shall be provided for all hospitals which:

a. meet or exceed the Disproportionate Share Threshold as defined in Subsection 451.12.

b. have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services, and has provided such services to individuals entitled to such services under the Idaho Medical Assistance Program for the reporting period.

i. Subsection 454.02.b does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or

ii. Did not offer non-emergency inpatient obstetric services as of December21, 1987.

c. The MUR shall be not less than one percent (1%)

d. If a hospital exceeds both Disproportionate Share thresholds set forth in Subsection 451.12 and the criteria of Subsections 454.02 b and c are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 454.02 f through j.

e. In order to qualify for a DSH payment, a hospital located outside the State of Idaho shall:

i. Qualify under the mandatory DSH requirements set forth in this Section;

ii. Qualify for DSH payments from the state in which the hospital is located; and

iii. Receive $50,000 or more in payments for services provided to Idaho recipients during the year covered by the applicable DSH Survey.

f. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one half (1.5) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to two percent (2%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

g. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one half (1.5) standard deviations and less than two (2) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to four percent (4%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

h. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to six percent (6%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

i. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates exceeding twenty five percent (25%) but less than thirty percent (30%) shall receive a DSH payment equal to four percent (4%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

j. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding thirty percent (30%) shall receive a DSH payment equal to six percent (6%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

03. Out-of-State Hospitals Eligible for Mandatory DSH Payments. Out-of-state hospitals eligible for Mandatory DSH payments will receive DSH payments equal to one half (of the percentages provided for Idaho hospitals in Subsections 02.d through 02.j). Mandatory qualifications in sections 454.02.a, b, c, and e, must also be met.

04. Deemed Disproportionate Share Hospital (DSH) All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 454.02, will be designated a Deemed Disproportionate Share Hospital. Out of state hospitals will not be as Deemed DSH. The disproportionate share payment to a Deemed DSH hospital shall be the greater of:

a. Five dollars ($5.00) per Medicaid inpatient day included in the hospital's MUR computation; or

b. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the Disproportionate Share Hospital Allotment Amount less the Mandatory DSH payment amount divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals.

c. The Deemed DSH inpatient utilization rate will be each hospital's Idaho Medicaid inpatient days divided by the total number of patient days reported in the annual DSH survey.

d. Deemed DSH eligibility and payments are based on an allocation of the remaining DSH allotment after Mandatory DSH hospital obligations are met. If Mandatory DSH hospitals receive 100 percent of the DSH allotment, deemed DSH hospitals will not be eligible to receive a DSH payment for that allotment period.

05. Insufficient DSH Allotment Amount. When the DSH Allotment Amount is insufficient to make the aggregate amount of DSH payments, DSH payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. On a quarterly basis, the state shall monitor DSH payments against the DSH Allotment Amount.

06. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the uncompensated costs incurred during the year of furnishing services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State plan, plus the costs of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients.

a. Payments made to a hospital for services provided to indigent patients by a State or a unit of local government within a State shall not be considered a source of third party payment.

b. Claims of uncompensated costs that increase the maximum amount which a hospital may receive as a DSH payment must be documented.

455. ORGAN TRANSPLANT AND PROCUREMENT REIMBURSEMENT Organ transplant and procurement services by facilities approved for kidneys, bone marrow, liver, or heart will be reimbursed the lesser of ninety-six an half (96.5%) of Reasonable Cost under Medicare payment principles or Customary Charges. Follow up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will not be covered.

456. OUT-OF-STATE HOSPITALS.

01. Cost Settlements for Certain Out-of- Hospitals. Hospitals not located in the State of Idaho will have a cost settlement computed with the State of Idaho if the following